PACE Advocates Push OMB, CMS To Consider Alternatives For Service Delivery, Care Coordination Reqs

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Senior care advocates are pushing the federal government to consider proposing regulatory alternatives to current service delivery and care coordination requirements for Programs of All-Inclusive Care for the Elderly organizations, with the goal of minimizing negative impacts on PACE organizations due in part to third-party actions. Specifically, the advocates want more services excluded from PACE care reporting requirements as well as deadlines stretched out for those that fall under the requirements.

PACE is a program that provides care for Medicare beneficiaries who do not live in a nursing home but need that level of care, and experts say these beneficiaries are often dually enrolled in Medicare and Medicaid.

The National Programs of All-Inclusive Care for the Elderly Association (NPA) met with officials from CMS and the Office of Management and Budget (OMB) last week to discuss suggestions for the 2028 Medicare Advantage rule currently pending at OMB. One suggestion is that CMS more broadly define the types of services that are excluded from the fixed 48-hour and seven-day care coordination timeframes.

At issue is a policy from a 2025 rule that established fixed compliance timelines based on events that PACE organizations say they do not control. NPA claims the documentation detailing a provider's recommendation that an interdisciplinary team (IDT) uses to take action often arrives after CMS' suggested timeline has expired. These timeframes include 48 hours for an IDT to review and act on hospital, emergency department and urgent care recommendations, and seven calendar days for other provider recommendations. And despite the PACE organizations themselves being subject to these timelines, there are no federal regulations requiring providers to send records to a PACE organization within a set timeframe, or at all, NPA says.

NPA met with federal officials in July and said in documents presented at the Aug. 19 meeting that CMS seemed willing to explore alternatives to the fixed 48-hour and seven-day care coordination timeframes and recognized that documentation-access barriers are a legitimate operational concern. However, according to the same Aug. 19 meeting materials, CMS told NPA in July that any alternative must be an

objective standard that can be audited. The agency has twice rejected an unmeasurable “as expeditiously as possible” standard, NPA said.

NPA also wants the federal government to consider a more specific definition of "routine or preventive services" that are excluded from the care coordination timeframe rules. NPA proposes the rule exempt annual wellness visits, standing preventive screenings, scheduled follow-up on an established treatment plan, routine medication-management visits and scheduled dental, vision, or hearing checks. This would mean PACE organizations would no longer be required to document why they could not schedule a service that the definition establishes as routine or preventive.

NPA is proposing the 2028 rule include a documented-effort alternative compliance pathway that would not label PACE organizations noncompliant solely because the IDT has not received a complete provider recommendation, provided the organization submits proof of timely outreach to obtain a recommendation. Once the provider's complete recommendation arrives, the timeline restarts from the day of the receipt, rather than when the PACE organization requests the recommendation.

NPA has also proposed to OMB and CMS expanding the 48-hour timeframe for hospital and urgent care recommendations to 72 hours, arguing in meeting documents that "[w]eekend records-department closures and non-integrated [electronic medical record] systems delay [emergency department] and urgent-care documentation as much as inpatient documentation -- the barrier is records access, not clinical acuity." -- *Sigi Ris* (sris@iwpnews.com)